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No. 07-576

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SUPREME COURT, U.S.

IN THE

Supreme Court of the United States

COOK CHILDREN'S MEDICAL CENTER,

Petitioner,

v.

THE NEW ENGLAND PPO PLAN OF GENERAL CONSOLIDATED MANAGEMENT, INC; DEBORAH HANSEN, FIDUCIARY, and NEW ENGLAND LIFE INSURANCE COMPANY,

Respondents.

ON PETITION FOR A WRIT OF CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE FIFTH CIRCUIT

BRIEF IN OPPOSITION FOR RESPONDENT NEW ENGLAND LIFE INSURANCE COMPANY

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COUNTERSTATEMENT OF QUESTIONS PRESENTED

David G. Miller prospectively elected not to enroll his son, David C., in his employer's self-funded ERISA health plan. This election was in accordance with the Summary Plan Description (which expressly allowed employees to opt out of any offered benefits) and ERISA (which permits an employee to opt out of an employee benefit plan). When Petitioner thereafter submitted a claim for medical services rendered to David C., the Plan Administrator denied it.

Was the Plan Administrator's decision an abuse of discretion?

CORPORATE DISCLOSURE STATEMENT

Pursuant to Supreme Court Rule 29.6, Respondent New England Life Insurance Company makes the following disclosures:

Respondent New England Life Insurance Company is wholly owned by New England Holdings, Inc.

TABLE OF CONTENTS

	Page
Counterstatement of Questions Presented	i
Corporate Disclosure Statement	ii
Table of Cited Authorities	iv
Summary of the Case	1
Statement of Lack of Jurisdiction	2
Statement of the Case	3
Reasons for Denying the Petition	6
A. No Basis For Discretionary Review Exists	6
B. The Plan Administrator's Decision Was Properly Upheld Under The Time-Tested ERISA Standard	7
C. Public Policy Does Not Support A Different Result	11
Prayer	13

TABLE OF CITED AUTHORITIES

Page

CASES

Anthony v. Sullivan,
954 F.2d 289 (5th Cir. 1992) 8

Barnett v. Kaiser Found. Health Plan, Inc.,
832 F.3d 413 (9th Cir. 1994) 8

Booth v. Wal-Mart Stores, Inc. Assocs. Health & Welfare Plan,
201 F.3d 335 (4th Cir. 2000) 8

Carr v. Gates Health Care Plan,
195 F.3d 292 (7th Cir. 1999) 8

Deters v. Secretary of Health, Educ. & Welfare,
789 F.2d 1181 (5th Cir. 1986) 8

Ellis v. Liberty Life Assur. Co.,
394 F.3d 262 (5th Cir. 2005) 8, 9

Firestone Tire & Rubber Co. v. Bruch,
489 U.S. 101, 109 S.Ct. 948 (1989) 6, 7

Fletcher-Merrit v. NorAm Energy Corp.,
250 F.3d 1174 (8th Cir. 2001) 8

Geddes v. United Staffing Alliance Employee Medical Plan,
469 F.3d 919 (10th Cir. 2006) 8

Cited Authorities

Page

Gillam v. Nevada Power Co.,
488 F.3d 1189 (9th Cir. 2007) 6

HECI Exploration Co. v. Holloway,
862 F.2d 513 (5th Cir. 1988) 9

Hubbard v. U.S.,
514 U.S. 695, 115 S.Ct. 1754 (1995) 2, 7

Kosakow v. New Rochelle Radiology Assocs., P.C.,
274 F.3d 706 (2d Cir. 2001) 6

Laniok v. Advisory Comm. of the Brainerd Mfg. Co. Pension Plan,
935 F.2d 1360 (2d Cir. 1991) 9-10

Leahy v. Raytheon Co.,
315 F.3d 11 (1st Cir. 2002) 6

Meditrust Fin. Servs. v. Sterling Chems.,
168 F.3d 211 (5th Cir. 1999) 7, 8, 9

STATUTES AND REGULATIONS

42 C.F.R. § 433.139(b)(1) 11

29 U.S.C. § 1002(8) 9

29 U.S.C. § 1053(b)(1)(B) 10

29 U.S.C. § 1104(a)(1)(D) 10

Cited Authorities

Page

COURT RULES

SUP. CT. R. 10 ..... 1, 2, 3, 7

SUP. CT. R. 10(a) 2

SUP. CT. R. 10(b) 2

SUP. CT. R. 10(c) 2

SUP. CT. R. 29.6 ii

SUMMARY OF THE CASE

This case does not involve any of the grounds set forth in Supreme Court Rule 10 or any compelling reason to justify discretionary review. Instead, this case seeks review of an ERISA plan administrator's well-founded decision to deny a routine claim for benefits.

When Petitioner Cook Children's Medical Center ("Cook") accepted David C. as a patient for the medical care in question, Cook did so with the understanding that David C. would be covered by Medicaid at Medicaid's discounted rate. (*See* R4:103, 58 at 223-24.) Thereafter, Cook accepted payment from Medicaid. (R4:103, 58 at 215; *id.* at 258.) Cook later returned the discounted payment to Medicaid and sought reimbursement – at higher rates – from the self-funded ERISA health plan (the "Plan") offered by David C.'s father's employer. (R4:103, 58 at 258; 215 [Ex. 4 – APP. 215].)

However, David C.'s father ("Mr. Miller") had previously elected not to enroll David C. in the Plan. (R4:103, 58 at 3.) Therefore, David C. was not enrolled in the Plan at the time Cook provided medical services. (*Id.*) Accordingly, the Plan Administrator denied Cook's claim, (R4:103, 58 at 15,) Both the district court and the court of appeals found that there was substantial evidence to support the Plan Administrator's decision and that, as a matter of law, the Plan Administrator did not abuse her discretion.

STATEMENT OF LACK OF JURISDICTION

This case does not provide grounds for the Court's discretionary review. Cook has not identified any opinion from this Court, another U.S. court of appeals, or state court of last resort that conflicts with the Fifth Circuit's opinion below. *See* SUP. CT. R. 10(a),(c). Nor does Cook seek review of an opinion from a state court of last resort. *Id.* at 10(b).

Furthermore, this case does not involve an important question of federal law requiring the Court's attention. *Id.* at 10(c). Instead, this case simply seeks review of an ERISA plan administrator's decision to deny a claim for benefits. The applicable standards are well established.

Cook attempts to inject controversy into the Fifth Circuit's opinion by arguing that Mr. Miller's decision not to enroll his child in an ERISA plan was contrary to Medicaid and public policy. However, as shown in Section C, below, neither Medicaid nor public policy prohibited Mr. Miller from exercising his right *not* to enroll David C. Moreover, neither the judicial system nor ERISA has ever imposed a requirement upon a plan administrator to determine, in considering a claim, whether a plan participant's prior election comported with Medicaid law.

This case does not represent a conflict or departure from precedent and does not present any important question of federal law. Because there is no compelling reason for review, the Petition should be denied. *See* SUP. CT. R. 10; *Hubbard v. U.S.*, 514 U.S. 695, 720, 115 S.Ct. 1754, 1767 (1995) (Rehnquist, C.J., dissenting)

(stating general principle that Supreme Court Rule 10 "embodies the standards by which we decide to grant review").

STATEMENT OF THE CASE

Through his employer, Mr. Miller received the opportunity to participate in the Plan. (R4:103, 58 at 13.) Mr. Miller's employer contracted with New England Life Insurance to provide certain administrative services to the Plan. (*See id.*) Respondent Deborah Hansen was the Plan Administrator. (*Id.* at 103.)

The Plan's open enrollment period began on March 1, 2002 and ended on March 31, 2002. (R4:103, 58 at 13.) The Plan's effective date was April 1, 2002. (*Id.*) At the inception of the open enrollment period, Mr. Miller listed David C. on his enrollment form as one of his dependents to be enrolled in the Plan. (*Id.* at 2, 13.) However, on March 31, 2002 – still during open enrollment and before the effective date of the Plan – Mr. Miller removed David C. from his enrollment form by crossing through David C.'s name. (R4:103, 58 at 2-3, 13, 193.) He also told the Plan Administrator to remove David C. from his enrollment application. (*Id.*) Pursuant to Mr. Miller's instructions, the Plan Administrator did not enroll David C. in the Plan. (*Id.*)

Mr. Miller, who is college educated, had nearly a month to make the enrollment decision. (R4:103, 58 at 2-3.) He had the opportunity to speak to an attorney or seek other assistance if he wanted to do so. (R4:103, 58 at 3.) In deciding whether to enroll David C. in the Plan, Mr. Miller did not look to or ask the Plan, Plan

Administrator, New England, General Consolidated, or anyone affiliated with them for advice. (R4:103, 58 at 3.) Nothing they said or did caused Mr. Miller to decide not to enroll David C. in the Plan. (*Id.*)

Instead, Mr. Miller made his decision voluntarily after he and his wife consulted with various Medicaid and Social Security Administration officials. (*Id.*) From the Millers' perspective, they decided to remove David C.'s name from the enrollment form in the best interests of David C. and the family. (R4:103, 58 at 3-4.) They did not intend to mislead anyone by exercising their right not to enroll their son in the Plan, and they do not feel that anyone has misled them. (*See* R4:103, 58 at 4.)

Thereafter, from April 9, 2002 through April 22, 2002, David C. underwent medical treatment at Cook. (R4:103, 58 at 4.) The evidence shows, and Cook acknowledged in its briefing below, that Cook knowingly accepted David C. as a patient for this care with the understanding that Medicaid would be the payor. (R:103, 58 at 223-24.)

In fact, Medicaid did pay Cook for all of the services at issue in this matter. (R4:103, 58 at 215.) Medicaid used the rate set by Medicaid's contract with Cook, which resulted in a payment of approximately $76,291.63. (*Id.*) Subsequently, Cook returned that payment and demanded payment from the Plan for $138,000.00. (R4:103, 58 at 258; *id.* at 215; AB at 6.)

Upon receipt of Cook's demand, the Plan Administrator reviewed the Summary Plan Description and the administrative record. (R4:103, 58 at 15.) The Plan provides that "[t]he Plan Administrator has

complete authority to control and manage the Plan. The Plan Administrator has full discretion to determine eligibility, to interpret the Plan and to determine whether a claim should be paid or denied, according to the provisions of the Plan as set forth in this booklet." (R4:103, 58 at 33.)

The Summary Plan Description further provides that the employee "may elect not to be covered under this Plan for any benefits or you may waive coverage for all coverages except Life and AD&D Insurance, or you may waive coverage for medical and prescription drug only." (R4:103, 58 at 32; RE at Tab 1.) Because David C. was not enrolled in the Plan during April 2002, David C. was not eligible for the benefits sought by Cook. (R4:103, 58 at 15.) Accordingly, the Plan denied Cook's request for payment. (*Id.*)

Cook filed suit to recover these benefits and had approximately a year to conduct discovery and take any depositions that it felt were necessary. (R1:21 at 8; R3:88 at 436.) On September 14, 2005, the district court granted summary judgment in favor of New England, the Plan, and the Plan Administrator and denied relief to Cook. (R2:88 at 436.) On appeal, the Court of Appeals for the Fifth Circuit properly applied the summary judgment and ERISA standards of review. *Petition* at 9a-13a. Like the district court, the court of appeals found that the Plan Administrator did not abuse her discretion in denying Cook's benefits claim. *Id.* at 14a-16a.

Unsatisfied with this result, Cook now petitions the Court to review and reverse both the court of appeals' and the district court's well-reasoned and amply-

supported determinations that the ERISA Plan Administrator did not abuse her discretion in denying benefits to Cook.

REASONS FOR DENYING THE PETITION

Cook's Petition focuses on a single issue: whether Mr. Miller's knowing and voluntary election to exercise his legal right not to enroll his son in an ERISA plan violated public policy. Cook does not dispute in its Petition that the administrative record fully supports the Plan Administrator's decision. Instead, Cook contends that the lower courts should have departed from the well-accepted standard of review, ignored the fact that the administrative record supported the Plan Administrator's decision, and invalidated the waiver based on public policy principles.

A. No Basis For Discretionary Review Exists

There is no basis for the Court to exercise its discretion and review this case. Cook requests review of an ERISA plan administrator's decision to deny a claim for benefits. It is well established that, when an ERISA plan grants discretion to a plan administrator, courts review the administrator's benefit determination for abuse of discretion. *See Firestone Tire & Rubber Co. v. Bruch*, 489 U.S. 101, 115, 109 S.Ct. 948, 957 (1989) (setting forth basic standard); *see also, e.g., Gillam v. Nevada Power Co.*, 488 F.3d 1189, 1193 (9th Cir. 2007) (discussing basic *Firestone* framework); *Leahy v. Raytheon Co.*, 315 F.3d 11, 15 (1st Cir. 2002) (applying *Firestone* "ground rules"); *Kosakow v. New Rochelle Radiology Assocs., P.C.*, 274 F.3d 706, 737-38 (2d Cir. 2001)

(determining standard in accordance with *Firestone* and "several past [Second Circuit] decisions"); *Meditrust Fin. Servs. v. Sterling Chems.*, 168 F.3d 211, 213 (5th Cir. 1999) (applying basic *Firestone* standard).

Cook attempts to gain footing by arguing that the plan participant's knowing and voluntary decision not to enroll his child in an ERISA plan was contrary to Medicaid and public policy. As shown in Section C, neither Medicaid nor public policy required Mr. Miller to enroll David C. in the Plan. Nor was the Plan Administrator required to look beyond the claim and determine whether Mr. Miller's decision not to enroll David C. violated Medicaid or public policy.

Because there is no basis to grant review, the petition should be denied. *See* SUP. CT. R. 10; *Hubbard*, 514 U.S. at 720, 115 S.Ct. at 1767 (Rehnquist, C.J., dissenting) (stating general principle that Supreme Court Rule 10 "embodies the standards by which we decide to grant review").

B. The Plan Administrator's Decision Was Properly Upheld Under The Time-Tested ERISA Standard

If an ERISA plan grants a plan administrator discretion, the administrator's benefit determinations are reviewed for abuse of discretion. *See Firestone*, 489 U.S. at 115, 109 S.Ct. at 957; *Meditrust Fin.*, 168 F.3d at 213. An administrator abuses her discretion only when she acts in an "arbitrary and capricious" manner. *Meditrust Fin.*, 168 F.3d at 214-16. A decision is

arbitrary only if made without a rational connection between: (1) the known facts and the decision; or (2) the found facts and the evidence. *Id.* at 215.

"When reviewing for arbitrary and capricious actions resulting in an abuse of discretion, [a court will] affirm an administrator's decision if it is supported by substantial evidence." *See id.* at 215. Only a minimal showing is required to satisfy the "substantial evidence" standard. *See Ellis v. Liberty Life Assur. Co.*, 394 F.3d 262, 273 (5th Cir. 2005). Substantial evidence is "such relevant evidence as a reasonable mind might accept as adequate to support a conclusion." *Id.* at 273. It must be more than a scintilla but is less than a preponderance. *Id.*; *see also Anthony v. Sullivan*, 954 F.2d 289, 295 (5th Cir. 1992); *Deters v. Secretary of Health, Educ. & Welfare*, 789 F.2d 1181, 1185 (5th Cir. 1986).

The reasonableness of an administrator's interpretation should be the focus of the court's inquiry – not whose interpretation of the plan is most persuasive. *Barnett v. Kaiser Found. Health Plan, Inc.*, 32 F.3d 413, 416 (9th Cir. 1994); *see also Geddes v. United Staffing Alliance Employee Medical Plan*, 469 F.3d 919, 929 (10th Cir. 2006); *Fletcher-Merrit v. NorAm Energy Corp.*, 250 F.3d 1174, 1180 (8th Cir. 2001); *Booth v. Wal-Mart Stores, Inc. Assocs. Health & Welfare Plan*, 201 F.3d 335, 344 (4th Cir. 2000); *Carr v. Gates Health Care Plan*, 195 F.3d 292, 294 (7th Cir. 1999). Thus, when a court reviews a plan administrator's waiver determination, the central inquiry is not whether the party, in fact, waived his right, "but whether the Plan administrator acted arbitrarily or capriciously *in determining* that [the party] had

waived his rights." *HECI Exploration Co. v. Holloway*, 862 F.2d 513, 523 (5th Cir. 1988) (emphasis in original).

A claimant bears the burden of proving that a plan or plan administrator abused its discretion. *See id. at* 523 n.17. However, a district court is not required to rule in favor of an ERISA claimant merely because it has supported its claim with substantial, or even a preponderance of, evidence. *Ellis*, 394 F.3d at 273. To the contrary, if the *plan administrator's* decision is supported by substantial evidence and is not arbitrary and capricious, it must prevail. *Id.*

In the case at hand, the Plan Administrator did not abuse her discretion. It is undisputed that David C. was not enrolled in the Plan at the time the services were provided. (R4:103, 58 at 13.) Because Mr. Miller elected not to enroll David C. under the Plan, David C. was not covered by the Plan for these services. Consequently, there was substantial evidence to support the Plan Administrator's decision, and a rational connection existed between the known facts and evidence and the found facts and decision to deny Cook's claim. *See Meditrust Fin.*, 168 F.3d at 215.

In fact, the Plan Administrator had no authority or discretion to approve and pay Cook's claim. The Plan itself provided that an employee could elect not to be covered in whole or in part. (R4:103, 58 at 33; RE at Tab 1.) Similarly, Congress has provided that an ERISA plan participant has the right to designate his/her beneficiaries, *see* 29 U.S.C. § 1002(8), and need not participate in an ERISA plan. *See e.g., Laniok v. Advisory Comm. of the Brainerd Mfg. Co. Pension Plan*,

935 F.2d 1360, 1365 (2d Cir. 1991); 29 U.S.C. § 1053(b)(1)(B). Thus, the Plan Administrator had no discretion under ERISA to do anything but follow Mr. Miller's instructions not to enroll David C. and deny Cook's claim. *See* 29 U.S.C. § 1104(a)(1)(D) (requiring that a plan administrator discharge her duties in accordance with the documents and instruments governing the plan).

Cook essentially argues that the Plan Administrator should have negated Mr. Miller's enrollment decision and retroactively deemed David C. as enrolled, based on the contention that Mr. Miller's decision violated laws other than ERISA. As the Fifth Circuit correctly noted in its underlying opinion, neither the courts nor ERISA have ever imposed a requirement upon a plan administrator to determine, in considering a claim, whether a plan participant's prior election comported with Medicaid law. *Petition* at 14a. They should not. It is unreasonable and unworkable to require ERISA plan administrators to look beyond ERISA and the administrative record and determine whether a participant's enrollment decision violated any other laws or public policy. Plan administrators do not have the expertise or qualifications to make such a determination. Furthermore, the burden of such a requirement would dramatically increase the costs incurred by ERISA plans, thus defeating ERISA's purpose.

Cook has not provided any basis for this Court to reach a decision different from the district court's and court of appeals' determination. The Plan Administrator did not abuse her discretion.

C. Public Policy Does Not Support A Different Result

Cook argues that Mr. Miller's decision not to enroll David C. contravened Medicaid and public policy. Neither Medicaid nor public policy requires a person to enroll himself or his children in an ERISA benefit health plan. Medicaid simply provides rules and standards that apply *if a person chooses to enroll in a private insurance plan.*

Cook notes that federal policy and law require Medicaid to be the payor of last resort. *Petition* at 7. This principle is not at issue here. Certainly, if a person has chosen to enroll in a private insurance plan and the claim is covered, Medicaid will be secondary to the private insurance plan. *Id.*; 42 C.F.R. § 433.139(b)(1). However, in this case, Mr. Miller lawfully and prospectively chose not to enroll David C. in the Plan. Because David C. was not enrolled in the Plan at the time Cook provided services and there was no private insurance, Medicaid was the payor of last resort, in accordance with law and any underlying policy.

In addition, Cook contends that a misrepresentation or failure to disclose the facts when attempting to obtain Medicaid benefits is contrary to both the law and public policy. *Petition* at 8. For instance, if Mr. Miller had chosen to enroll David C. in the Plan at the outset, and then had lied about David C.'s enrollment (or failed to disclose it), then he may have violated the law. However, the facts of the case are dramatically different. There is no evidence of any dishonesty or misrepresentation by Mr. Miller or any of the Miller family, to the government or to Cook.

Instead, the evidence shows that:

(1) the Summary Plan Description gave Mr. Miller the option not to enroll for all or part of the benefits offered;

(2) there is no law – Medicaid-related or otherwise – that forbade the Plan from making enrollment optional or that required Mr. Miller to enroll to the full limits of the Plan;

(3) Mr. Miller and his wife consulted openly with Medicaid and Social Security Administration representatives about their decision;

(4) during the Plan enrollment period, Mr. Miller chose not to enroll David C. in the Plan and communicated this election to the Plan in several ways;

(5) David C. received medical services from Cook during the time he was not enrolled in the Plan; and

(6) Cook expected to receive payment from Medicaid when it admitted David C and, in fact, received payment from Medicaid at the agreed-upon Medicaid rate.

This is not a dispute regarding a plan's or insured's attempt to evade Medicaid law or public policy. Rather, this is a case in which Cook asks the judicial system to rewrite the private agreement between the Plan and Mr.

Miller, to create ERISA insurance coverage where none exists, and to effectively legislate new language and policy into Medicaid statutes that would require U.S. citizens to enroll to the full limit in any and all reasonably available insurance. Had Congress wanted to impose this requirement on its constituency, it could have done so. No such requirement appears in any of the laws or regulations cited by Cook.

PRAYER

Respondent New England Life Insurance Company prays that the Court deny the Petition for Writ of Certiorari and the relief requested therein.

Respectfully submitted,

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